

		FOR OHF USE					

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**2004**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2004)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0031906</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																									
<b>Facility Name:</b> <u>Genesis House</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/03</u> to <u>06/30/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
<b>Address:</b> <u>350 Sycamore Road</u> <u>Genoa</u> <u>60135</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
<b>County:</b> <u>DeKalb</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
<b>Telephone Number:</b> <u>( 815 ) 784-5146</u> <b>Fax #</b> <u>( 815 ) 784-2594</u>		<b>Paid Preparer</b> (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # (312) 634-5518																									
<b>IDPA ID Number:</b> <u>363480754002</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
<b>Date of Initial License for Current Owners:</b> <u>12/08/1986</u>																											
<b>Type of Ownership:</b> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
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	<input checked="" type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Christine A. Hanover</u> <b>Telephone Number:</b> <u>(312) 384-6000</u> <b>Please send copies of desk review and audit adjustments to address on this page</b>																											

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House# 0031906 Report Period Beginning: 07/01/03 Ending: 06/30/04

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>60</u>	Intermediate/DD	<u>60</u>	<u>21,960</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>60</u>	TOTALS	<u>60</u>	<u>21,960</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>21,348</u>			<u>21,348</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,348</u>			<u>21,348</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 97.21%

D. How many bed-hold days during this year were paid by Public Aid?

347 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been  
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/07/86

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 12/07/86NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒

If YES, enter number

of beds certified            and days of care provided N/AMedicare Intermediary N/A

## IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH\* ☐CASH\* ☐

Is your fiscal year identical to your tax year?

YES ☐ NO ☒Tax Year: 12/31/04 Fiscal Year: 06/30/04

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Genesis House # 0031906 Report Period Beginning: 07/01/03 Ending: 06/30/04

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	100,179	11,038	6,968	118,185		118,185		118,185		1
2	Food Purchase		111,073		111,073		111,073	(13,041)	98,032		2
3	Housekeeping	71,091	12,929	64	84,084		84,084		84,084		3
4	Laundry	19,028	10,455	176	29,659		29,659		29,659		4
5	Heat and Other Utilities			48,357	48,357		48,357		48,357		5
6	Maintenance	39,481	19,354	38,063	96,898		96,898	(1,964)	94,934		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	229,779	164,849	93,628	488,256		488,256	(15,005)	473,251		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	745,465	16,146	59,271	820,882		820,882		820,882		10
10a	Therapy			4,545	4,545		4,545		4,545		10a
11	Activities	41,224	3,259	2,858	47,341		47,341		47,341		11
12	Social Services	1,825		1,495	3,320		3,320		3,320		12
13	Nurse Aide Training	26,872	438		27,310		27,310		27,310		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	815,386	19,843	92,169	927,398		927,398		927,398		16
	<b>C. General Administration</b>										
17	Administrative	340,092			340,092		340,092		340,092		17
18	Directors Fees										18
19	Professional Services			73,887	73,887		73,887	(6,185)	67,702		19
20	Dues, Fees, Subscriptions & Promotions			4,959	4,959		4,959	692	5,651		20
21	Clerical & General Office Expenses	59,814	9,955	16,277	86,046		86,046	(31)	86,015		21
22	Employee Benefits & Payroll Taxes			170,367	170,367		170,367	13,041	183,408		22
23	Inservice Training & Education			1,250	1,250		1,250		1,250		23
24	Travel and Seminar			7,446	7,446		7,446		7,446		24
25	Other Admin. Staff Transportation			5,713	5,713		5,713		5,713		25
26	Insurance-Prop.Liab.Malpractice			31,477	31,477		31,477		31,477		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	399,906	9,955	311,376	721,237		721,237	7,517	728,754		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,445,071	194,647	497,173	2,136,891		2,136,891	(7,488)	2,129,403		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Genesis House

#0031906

Report Period Beginning:

07/01/03

Ending:

06/30/04

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			38,300	38,300		38,300	12,631	50,931			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			54,640	54,640		54,640	(23,878)	30,762			32
33	Real Estate Taxes							18,799	18,799			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	(240,000)				34
35	Rent-Equipment & Vehicles			53,768	53,768		53,768		53,768			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			386,708	386,708		386,708	(232,448)	154,260			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			3,380	3,380		3,380		3,380			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			167,544	167,544		167,544		167,544			42
43	Other (specify):* <b>Nonallowable Costs</b>			950,315	950,315		950,315	(950,315)				43
44	<b>TOTAL Special Cost Centers</b>			1,121,239	1,121,239		1,121,239	(950,315)	170,924			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,445,071	194,647	2,005,120	3,644,838		3,644,838	(1,190,251)	2,454,587			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Genesis House

# 0031906

Report Period Beginning: 07/01/03

Ending: 06/30/04

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	31	30		9
10 Interest and Other Investment Income	(42,366)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(252)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees	(150)	20		17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(100)	43		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax	(3,526)	43		26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule 5a	(957,964)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,004,327)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(185,924)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (185,924)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (1,190,251)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

**Genesis House**  
**Provider #: 0031906**  
**07/01/03 to 06/30/04**

**Schedule 5A**

Schedule VI. Part a - Adjustment Detail, Line 29

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
Day Training	(939,545)	43
Vending Machines	(5,515)	43
Deferred Maintenance	(1,964)	6
Non-allowable professional fees	(9,563)	19
Out-of-period expenses	(1,377)	43
Total	<u>(957,964)</u>	

**SEE ACCOUNTANTS' COMPILATION REPORT**

Genesis House

ID# 0031906

Report Period Beginning: 07/01/03

Ending: 06/30/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
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31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

06/30/04

[illegible]

## Summary B

06/30/04

[illegible]

Facility Name & ID Number      **Genesis House**#      **0031906**

Report Period Beginning:

**07/01/03**

Ending:

**06/30/04**

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Catherine Bachand	100			Ma Retraite LLC	Genoa	Real Estate Holding
				Avancer LLC	Genoa	CILA Operations
				Ma Maison LLC	Genoa	CILA Real Estate
				Bonheur Senior	Genoa	SLF Real Estate
				Options LLC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.      ☒ YES      ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional fees	\$	Ma Retraite LLC	100.00%	\$ 3,378	\$ 3,378	1
2	V	20	Dues, fees, subscriptions		Ma Retraite LLC	100.00%	250	250	2
3	V	21	Office supplies		Ma Retraite LLC	100.00%	561	561	3
4	V	30	Depreciation		Ma Retraite LLC	100.00%	12,600	12,600	4
5	V	32	Interest		Ma Retraite LLC	100.00%	18,488	18,488	5
6	V	33	Real estate taxes		Ma Retraite LLC	100.00%	18,799	18,799	6
7	V	34	Rent - facility and grounds		Ma Retraite LLC	100.00%	(240,000)	(240,000)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ (185,924)	\$ * (185,924)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Genesis House      #      0031906      Report Period Beginning:      07/01/03      Ending:      06/30/04

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Catherine Bachand	Administrator	Administration	100.00	95,907	36	75.00	Salary	\$ 295,232	L17, C1	1
2											2
3											3
4											4
5	Note: The \$95,907 is received from the Day Training Program that is run by Genesis Enterprises. The amount is										5
6	adjusted out on line 43.										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 295,232		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House# 0031906

Report Period Beginning:

07/01/03Ending: 06/30/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

Fax Number (\_\_\_\_) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7	N/A								7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/03 Ending: 06/30/04

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	Advance Leasing Corp		x	Heating and cooling system	\$803.00	9/99	\$ 33,301	\$ 1,574	9/04	0.1573	\$ 1,000	1							
2	ABB Business Finance		x	Telephone system	\$394.00	12/01	16,957	9,935	12/06	0.1396	1,626	2							
3	GreatAmerican Leasing		x	Time Clock	\$339.00	3/02	9,217	2,520	3/05	0.1902	822	3							
4	Alliance Laundry		x	Washing Machines	\$385.00	9/03	18,764	16,160	9/08	0.0850	1,247	4							
5	See Schedule 9A				\$4,050.00		557,160	363,300			28,549	5							
	Working Capital																		
6	Resource Bank		x	Working capital	N/A	4/02	Various			0.1140	45,151	6							
7												7							
8												8							
9	TOTAL Facility Related				\$5,971.00		\$ 635,399	\$ 393,489			\$ 78,395	9							
	B. Non-Facility Related*																		
10	Interest income offset										(47,633)	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			(47,633)	14							
15	TOTALS (line 9+line14)						\$ 635,399	\$ 393,489			\$ 30,762	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ -0- Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Genesis House  
 Provider # 0031906  
 6/30/04

Schedule 9 A

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Resource Bank		x	Mortgage	\$4,050.00	2/02	\$ 450,000	\$ 271,162	3/12	Prime	\$ 21,612	1	
2	Ma Retraite	x		Roof	N/A	10/03	53,580	48,399	10/08	0.1400	4,793	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Resource Bank		x	Line of Credit	N/A	10/03	53,580	43,739	10/06	0.0632	2,144	6	
7												7	
8												8	
9	TOTAL Facility Related				\$4,050.00		\$ 557,160	\$ 363,300			\$ 28,549	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14	
15	TOTALS (line 9+line14)						\$ 557,160	\$ 363,300			\$ 28,549	15	

See Accountants' Compilation Report

Facility Name & ID Number **Genesis House**# **0031906** Report Period Beginning: **07/01/03** Ending: **06/30/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2003 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>19,710</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2003	\$	<b>19,210</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(500)</b>	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>19,299</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>18,799</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1999	<b>24,227</b>	8
	2000	<b>17,406</b>	9
	2001	<b>18,708</b>	10
	2002	<b>19,211</b>	11
	2003	<b>19,199</b>	12

<b>2nd installment of 2003 - 9,599</b>	<b>Real Estate Taxes Paid include:</b>		<b>FOR OHF USE ONLY</b>	
<b>1/2 of 2004 taxes 9,700</b>	<b>2003 taxes paid 9,600</b>		13 FROM R. E. TAX STATEMENT FOR 2003 \$	13
	<b>2002 taxes paid 9,610</b>		14 PLUS APPEAL COST FROM LINE 5 \$	14
<b>2004 accrual 19,299</b>	<b>Total 19,210</b>		15 LESS REFUND FROM LINE 6 \$	15
			16 AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Genesis House COUNTY DeKalb

FACILITY IDPH LICENSE NUMBER 0031906

CONTACT PERSON REGARDING THIS REPORT Catherine Bachand

TELEPHONE ( 815 ) 784-5146 FAX #: ( 815 ) 734-7131

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>03-29-152-010</u>	<u>350 Sycamore Road, Genoa, IL</u>	\$ <u>19,199.00</u>	\$ <u>19,199.00</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		<b>TOTALS</b>	\$ <u>19,199.00</u>	\$ <u>19,199.00</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services?        YES   x   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,500
 B. General Construction Type:
 Exterior Brick
 Frame Wood
 Number of Stories 1

C. Does the Operating Entity?
 (a) Own the Facility
 (b) Rent from a Related Organization.
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 (a) Own the Equipment
 (b) Rent equipment from a Related Organization.
 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES
 NO
 If so, please complete the following:

1. Total Amount Incurred: N/A
 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A
 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	92,000	2002	\$ 122,310	1
2					2
3	TOTALS	92,000		\$ 122,310	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Genesis House

# 0031906

Report Period Beginning:

07/01/03

Ending:

06/30/04

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	60	2002	1972	\$ 440,888	\$	35	\$ 12,600	\$ 12,600	\$ 27,299
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Leasehold improvements	1988		572		15			572
10	Roof	1992		34,891		15	2,326	2,326	29,075
11	Plumbing	1991		1,594		5			1,594
12	Office furniture partitions	1992		4,192		15	280	280	3,220
13	Office furniture partitions	1993		1,302		15	87	87	1,001
14	Landscaping	1993		13,295		15	886	886	10,189
15	Tile	1993		5,177		15	345	345	3,968
16	Drywall	1993		2,500		15	167	167	1,920
17	Building repair	1994		1,485		30	49	49	467
18	Alarm system	1994		5,391		30	180	180	1,710
19	Road paving	1994		36,015		30	1,201	1,201	11,409
20	Window and door replacement	1994		27,934		30	931	931	8,845
21	Parking lot repair	1994		796		30	27	27	256
22	Heating and air conditioning	1994		15,850		30	528	528	5,015
23	Parking lot sidewalk repair	1995		64,241		30	2,141	2,141	18,199
24	Plumbing, heating, electrical, carpeting	1996		12,760		30	425	425	3,188
25	Building repair - new windows	1997		9,930	993	25	397	(596)	2,581
26	Building repair to kitchen	1998		4,137	410	25	165	(245)	1,073
27	Bathroom repairs	1998		11,990		25	480	480	2,640
28	Windows	1999		34,053	905	15	2,271	1,366	10,219
29	Shower door	1999		690	69	10	69		311
30	HVAC units	1999		77,202	5,610	15	5,147	(463)	23,161
31	Sealcoating	2002		2,108	210	15	140	(70)	350
32	Roof	2003		53,580	2,679	15	1,786	(893)	1,786
33	Non-facility depreciation				5,000			(5,000)	
34									
35									
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 862,573	\$ 15,876		\$ 32,628	\$ 16,752	\$ 170,048	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 139,482	\$ 20,329	\$ 16,208	\$ (4,121)	5-10	\$ 96,413	71
72	Current Year Purchases	20,953	2,095	2,095		5	2,095	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 160,435	\$ 22,424	\$ 18,303	\$ (4,121)		\$ 98,508	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1985 Ford Van	1987	\$ 13,039	\$	\$			\$ 13,039	76
77	Administrative	1996 Ford Escort	1995	14,431					14,431	77
78										78
79										79
80	TOTALS			\$ 27,470	\$	\$			\$ 27,470	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,172,788	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,300	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 50,931	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,631	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 296,026	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

N/A

N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 12,312

Description: Copier - \$ 5,927, Postage Meter - \$ 1,610, Server - \$ 1,500, Medical equip - \$ 3,275  
(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2005 \$                     

13.                      /2006 \$                     

14.                      /2007 \$                     

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Resident Care</u>	<u>Vans</u>	\$ <u>1768</u>	\$ <u>21,217</u>	17
18	<u>Administrative</u>	<u>2004 Lexus</u>	<u>1687</u>	<u>20,239</u>	18
19					19
20					20
21	TOTAL		\$	\$ 41,456	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>80</u>
		HOURS PER AIDE <u>40</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	
2	Books and Supplies		438		438
3	Classroom Wages (a)		14,072		14,072
4	Clinical Wages (b)		7,586		7,586
5	In-House Trainer Wages (c)		5,214		5,214
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 27,310	\$	\$ 27,310
10	SUM OF line 9, col. 1 and 2 (e)	\$	27,310		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	21
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	21

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	L39, C3	visits		35	2,100		35	2,100	5
6	Dental Care	L39, C3	visits		21	1,280		21	1,280	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	56	\$ 3,380	\$	56	\$ 3,380	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

**Genesis House**

**Provider #: 0031906**

**07/01/03 to 06/30/04**

**Schedule 16A**

XIV. Special Services

Line 13 Other (specify):

<u>Service</u>	<u>Line Reference</u>	<u>Outside Practioner Units</u>	<u>Cost</u>	<u>Supplies</u>
----------------	---------------------------	-------------------------------------	-------------	-----------------

**SEE ACCOUNTANTS' COMPILATION REPORT**

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Genesis House

# 0031906

Report Period Beginning: 07/01/03

Ending:

06/30/04

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/04

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 276,714	\$ 363,396	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 10,000 )	295,567	295,567	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,812	31,812	6
7	Other Prepaid Expenses	57	57	7
8	Accounts Receivable (owners or related parties)	(3,775)	90,686	8
9	Other(specify): Due from shareholder	688,071	688,071	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,288,446	\$ 1,469,589	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		122,310	13
14	Buildings, at Historical Cost		440,888	14
15	Leasehold Improvements, at Historical Cost	204,388	421,685	15
16	Equipment, at Historical Cost	166,664	187,905	16
17	Accumulated Depreciation (book methods)	(201,729)	(296,026)	17
18	Deferred Charges		1,964	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) Deposits	7,302	7,302	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 176,625	\$ 886,028	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,465,071	\$ 2,355,617	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 36,700	\$ 36,714	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	59,434	103,173	29
30	Accrued Salaries Payable	86,218	86,218	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,559	19,299	32
33	Accrued Interest Payable		1,757	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 198,911	\$ 247,161	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	19,154	19,154	39
40	Mortgage Payable		271,162	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 19,154	\$ 290,316	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 218,065	\$ 537,477	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,247,006	\$ 1,818,140	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,465,071	\$ 2,355,617	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,056,452	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,056,452	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	390,554	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(200,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 190,554	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 1,247,006	24 *

Operating Entity Only

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number Genesis House

# 0031906

Report Period Beginning: 07/01/03

Ending:

06/30/04

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,858,912	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,858,912	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	30,591	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,391	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 32,982	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	42,366	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 42,366	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Sch 19a	101,132	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 101,132	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,035,392	30

2			
	Expenses	Amount	
<b>A. Operating Expenses</b>			
31	General Services	488,256	31
32	Health Care	927,398	32
33	General Administration	721,237	33
<b>B. Capital Expense</b>			
34	Ownership	386,708	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	953,695	35
36	Provider Participation Fee	167,544	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,644,838	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	390,554	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 390,554	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Federal income tax return is filed using the cash basis on a calendar year.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Genesis Enterprises, Inc.  
PROVIDER # 0031906  
6/30/2004

**Schedule 19A**

**XVII. INCOME STATEMENT**

**Revenue**

<b><u>E. Other Revenue (specify):</u></b>	<b><u>Amount</u></b>
Management Fee Income	93,600
Vending Machine Income	7,512
Miscellaneous Income	20
<b>Total Line 28 - Other Revenue (specify):</b>	<b><u><u>101,132</u></u></b>

**See Accountants' Compilation Report**

Facility Name &amp; ID Number Genesis House

# 0031906

Report Period Beginning: 07/01/03

Ending:

06/30/04

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,819	1,963	\$ 51,184	\$ 26.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	178	178	3,598	20.21	3
4	Licensed Practical Nurses	5,367	5,461	98,142	17.97	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	2,548	2,548	26,872	10.55	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	506	537	9,213	17.16	9
10	Activity Assistants	4,111	4,417	32,011	7.25	10
11	Social Service Workers	100	106	1,825	17.22	11
12	Dietician	1,600	1,664	25,337	15.23	12
13	Food Service Supervisor					13
14	Head Cook	5,733	6,103	45,889	7.52	14
15	Cook Helpers/Assistants	4,540	4,540	28,953	6.38	15
16	Dishwashers					16
17	Maintenance Workers	3,927	4,230	39,481	9.33	17
18	Housekeepers	10,864	11,007	71,091	6.46	18
19	Laundry	2,562	2,700	19,028	7.05	19
20	Administrator	3,364	3,534	340,092	96.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,008	4,375	59,814	13.67	24
25	Vocational Instruction					25
26	Academic Instruction	1,169	1,251	17,773	14.21	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,049	3,380	48,444	14.33	28
29	Resident Services Coordinator	1,936	2,080	32,033	15.40	29
30	Habilitation Aides (DD Homes)	50,459	51,332	465,236	9.06	30
31	Medical Records	1,703	1,824	29,055	15.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	109,543	113,230	\$ 1,445,071 *	\$ 12.76	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	150	\$ 6,968	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	176	7,000	L10, C3	38
39	Pharmacist Consultant	Monthly	1,800	L10, C3	39
40	Physical Therapy Consultant	79	3,555	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	16	990	L10A, C3	43
44	Activity Consultant	47	2,858	L11, C3	44
45	Social Service Consultant	24	1,495	L12, C3	45
46	Other(specify)				46
47	Psychiatric Consultant	8	1,688	L10, C3	47
48	Psychological Consultant	107	6,825	L10, C3	48
49	TOTAL (lines 35 - 48)	607	\$ 57,179		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	1,231	41,958	L10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,231	\$ 41,958		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Genesis House

STATE OF ILLINOIS

# 0031906

Page 21

Report Period Beginning: 07/01/03

Ending: 06/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Catherine A. Bachand	Administrator	100	\$ 295,232
Desiree Henderson-Sawyer	Administrator	n/a	44,860
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 340,092

B. Administrative - Other

Description	Amount
N/A	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$

C. Professional Services

Vendor/Payee	Type	Amount
American Express Tax & Business	Accounting	\$ 33,494
Altschuler Melvoin & Glasser	Accounting	15,930
Piper Rudnick	Legal	6,913
Shelsky & Froelick Ltd	Legal	7,185
Information Controls	Computer services	2,991
Thelen Computer Consulting	Computer services	819
ADP	Payroll services	6,555
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$ 73,887

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 29,964
Unemployment Compensation Insurance	15,492
FICA Taxes	95,603
Employee Health Insurance	21,544
Employee Meals	13,041
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	7,764
TOTAL (agree to Schedule V, line 22, col.8)	\$ 183,408

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 1,500
Advertising: Employee Recruitment	2,119
Health Care Worker Background Check (Indicate # of checks performed 85 )	592
Licenses and permits	255
Dues and subscriptions	1,185
Less: Public Relations Expense	(  )
Non-allowable advertising	(  )
Yellow page advertising	(  )
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,651

G. Schedule of Travel and Seminar\*\*

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	7,446
Entertainment Expense	(  )
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 7,446

\* Attach copy of IMRF notifications

\*\*See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

**Genesis House**

**Provider #: 0031906**

**07/01/03 to 06/30/04**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

Total (agree to Schedule V, line 19, column 3)	73,887
Plus: Shefsky & Froelick Ltd from related party	2,378
American Express Tax & Business Services	1,000
Less: Shefsky & Froelick Ltd - non-allowable	(9,563)
Total (agree to Schedule V, line 19, column 8)	<u>67,702</u>

**SEE ACCOUNTANTS' COMPILATION REPORT**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

(continued from page 1)													
1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Roof repairs	12/03	\$ 1,849	3	\$	\$	\$	\$ 308	\$ 616	\$ 616	\$ 308	\$	\$
2	Roof repairs	2/04	508	3				85	169	169	86		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 2,357		\$	\$	\$	\$ 393	\$ 785	\$ 785	\$ 394	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number      Genesis House

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5.0
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 916 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 167,544  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 13,041 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0.0 %
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? Yes**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of service: performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	100,179	11,038	6,968	118,185	0	118,185	0	118,185
2. Food Purchase	0	111,073	0	111,073	0	111,073	-13,041	98,032
3. Housekeeping	71,091	12,929	64	84,084	0	84,084	0	84,084
4. Laundry	19,028	10,455	176	29,659	0	29,659	0	29,659
5. Heat and Other Utilities	0	0	48,357	48,357	0	48,357	0	48,357
6. Maintenance	39,481	19,354	38,063	96,898	0	96,898	-1,964	94,934
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	229,779	164,849	93,628	488,256	0	488,256	-15,005	473,251
9. Medical Director	0	0	24,000	24,000	0	24,000	0	24,000
10. Nursing & Medical Records	745,465	16,146	59,271	820,882	0	820,882	0	820,882
10a. Therapy	0	0	4,545	4,545	0	4,545	0	4,545
11. Activities	41,224	3,259	2,858	47,341	0	47,341	0	47,341
12. Social Services	1,825	0	1,495	3,320	0	3,320	0	3,320
13. Nurse Aide Training	26,872	438	0	27,310	0	27,310	0	27,310
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	815,386	19,843	92,169	927,398	0	927,398	0	927,398
17. Administrative	340,092	0	0	340,092	0	340,092	0	340,092
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	73,887	73,887	0	73,887	-6,185	67,702
20. Fees, Subscriptions & Promotion	0	0	4,959	4,959	0	4,959	692	5,651
21. Clerical & General Office	59,814	9,955	16,277	86,046	0	86,046	-31	86,015
22. Employee Benefits & Payroll	0	0	170,367	170,367	0	170,367	13,041	183,408
23. Inservice Training & Education	0	0	1,250	1,250	0	1,250	0	1,250
24. Travel and Seminar	0	0	7,446	7,446	0	7,446	0	7,446
25. Other Admin. Staff Trans	0	0	5,713	5,713	0	5,713	0	5,713
26. Insurance-Prop.Liab.Malpractice	0	0	31,477	31,477	0	31,477	0	31,477
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	399,906	9,955	311,376	721,237	0	721,237	7,517	728,754
29. Total General Administrative	1,445,071	194,647	497,173	2,136,891	0	2,136,891	-7,488	2,129,403
30. Depreciation	0	0	38,300	38,300	0	38,300	12,631	50,931
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	54,640	54,640	0	54,640	-23,878	30,762
33. Real Estate	0	0	0	0	0	0	18,799	18,799
34. Rent - Facility & Grounds	0	0	240,000	240,000	0	240,000	-240,000	0
35. Rent - Equipment & Vehicles	0	0	53,768	53,768	0	53,768	0	53,768
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	386,708	386,708	0	386,708	-232,448	154,260
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	3,380	3,380	0	3,380	0	3,380
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	167,544	167,544	0	167,544	0	167,544
43. Other (specify):*	0	0	950,315	950,315	0	950,315	-950,315	0
44. Total Special Cost Ce	0	0	1,121,239	1,121,239	0	1,121,239	-950,315	170,924
45. Grand Total	1,445,071	194,647	2,005,120	3,644,838	0	3,644,838	-1,190,251	2,454,587

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	276,716	363,396
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	295,567	295,567
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	31,812	31,812
7. Other Prepaid Expenses	57	57
8. Accounts Receivable-Owner/Related Party	-3,775	90,686
9. Other (specify):	688,071	688,071
10. Total current assets	1,288,448	1,469,589
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	122,310
14. Buildings, at Historical Cost	0	440,888
15. Leasehold Improvements, Historical Cost	204,388	421,685
16. Equipment, at Historical Cost	166,664	187,905
17. Accumulated Depreciation (book methods)	-201,729	-296,026
18. Deferred Charges	0	1,964
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	7,302	7,302
23. other (specify):	0	0
24. Total Long-Term Assets	176,625	886,028
25. Total Assets	1,465,073	2,355,617
CURRENT LIABILITIES		
26. Accounts Payable	36,700	36,714
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	59,434	103,173
30. Accrued Salaries Payable	86,218	86,218
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	16,559	19,299
33. Accrued Interest Payable	0	1,757
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	0	0
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	198,911	247,161
LONG TERM LIABILITES		
39. Long-Term Notes Payable	19,154	19,154
40. Mortgage Payable	0	271,162
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	19,154	290,316
46. Total Liabilities	218,065	537,477
47. Total Equity	1,247,008	1,818,140
48. Total Liabilities and Equity	1,465,073	2,355,617

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,858,912
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	3,858,912
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Ancillary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	30,591
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	2,391
22. Laundry	0
Subtotal - Other Operating Revenue	32,982
24. Contributions	0
25. Interest and Other Investments Income	42,366
Subtotal - Non-Operating Revenue	42,366
27. Other Revenue (specify):	101,132
28. Other Revenue (specify):	0
Subtotal - Other Revenue	101,132
30. Total Revenue	4,035,392
31. General Services	488,256
32. Health Care	930,673
33. General Administration	721,237
34. Ownership	383,433
35. Special Cost Centers	953,695
35. Provider Participation Fee	167,544
37. Other	0
40. Total Expenses	3,644,838
41. Income Before Income Taxes	390,554
42. Income Taxes	0
43. Net Income or Loss for the Year	390,554

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